PROVIDER INQUIRY FORM

--APPENDIX X

EDS
P.O.Box 2009
Frankfort, Ky. 40602

Please remit both copier of the Inquiry Form to EDS.

1. Provider Number	3. Recipient Name (first, last)	
2. Provider Name and Address	4. Medical Assistance Number	
	5. Billed Amount	6. Claim Service Date
	7. RA Date	a. Internal Control Number

9. Provider's Message

10. _____
Signature Date

Dear Provider:

This claim has been resubmitted for possible payment.

EDS can find no record of receipt of this claim. Please resubmit.

This claim paid on _____ in the amount of _____

We do not understand the nature of **your inquiry.** Please clarify.

_____ EDS can find no record of receipt of this claim in the last 12 months.

This claim was paid according to Medicaid guidelines.

_____ This claim was denied on _____ with **EOB** code _____

_____ Aged claim. Payment may not be made for services over 12 months old without proof that the **claim was** received by EDS within one year of the date of service; and if the **claim** rejects, you **must** show **timely receipt by EDS** within 12 months of that rejection date. Claims must be received by EDS every **12** months **to** be-considered for payment;--

Other: _____

_____

_____

_____

_____

_____
EOS Date

MAIL TO; EDS FEDERAL CORPORATION
P. 0. BOX 2009
FRANKFORT. KY 40602

APPENDIX XI

ADJUSTMENT REQUEST FORM

1. Original Internal Control Number (I.C.N.)	EDS FEDERAL USE ONLY		
2. Recipient Name	3. Recipient Medicaid Number		
4. Provider Name/Number/Address	5. From Oat8 Service	6. To Date Service	
	7. Billed Amt.	8. Paid Amt.	9. R.A. Oat8

10. Please specify WHAT is to be adjusted *on* **the claim.**

11. Please specify REASON for the adjustment request or Incorrect original claim payment.

IMPORTANT: **THIS FORM WILL BE RETURNED TO YOU IF THE REQUIRED INFORMATION AND DOCUMENTATION** FOR PROCESSING ARE NOT PRESENT. PLEASE ATTACH A COPY Of THE CLAIM **AND REMITTANCE** ADVICE TO **BE** ADJUSTED.

12. Signature 13. **Date**

EDSF USE **ONLY**---**DO** NOT WRITE BELOW THIS **LINE**

Field/Line:

New Data:

Previous Data:

Field/Line:

New data:

Previous Data:

Other Actions/Remarks:

[redacted]

APPROVED OMB-0938-0008

APPENDIX XII

PICA

HEALTH INSURANCE CLAIM FORM

MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER

1a. INSURED'S I.D. NUMBER | FOR PROGRAM IN ITEM 1

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED | DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. ID NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM | MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. | 2. | 3. | 4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# | GRP#

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

TRANSMITTAL #13 DATE

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8.881

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)

7/29/93

KENTUCKY MEDICAID PROGRAM

COMMUNITY MENTAL HEALTH MANUAL

POLICIES AND PROCEDURES

Cabinet for Human Resources
Department for Medicaid Services
Frankfort, Kentucky 40621

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COMMUNITY MENTAL HEALTH SERVICES APPENDIX

II. KENTUCKY MEDICAID PROGRAM

A. General Information

The Kentucky Medicaid Program, is administered by the Cabinet for Human Resources, Department for Medicaid Services. The Medicaid Program, identified as Title XIX of the Social Security Act, was enacted in 1965, and operates according to a State Plan approved by the U.S. Department of Health and Human Services.

Title XIX is a joint Federal and State assistance program which provides payment for certain medical services provided to Kentucky recipients who lack sufficient income or other resources to meet the cost of such care. The basic objective of the Medicaid Program is to aid the medically indigent of Kentucky in obtaining quality medical care.

The Department for Medicaid Services is bound by both federal and state statutes and regulations governing the administration of the State Plan. Medicaid cannot reimburse you for any services not covered by the plan. The state cannot be reimbursed by the federal government for monies improperly paid to providers of non-covered, unallowable medical services.

The Medicaid Program, Title XIX, is not to be confused with Medicare. Medicare is a Federal program, identified as Title XVIII, basically serving persons 65 years of age and older, and some disabled persons under that age.

B. Administrative Structure

The Department for Medicaid Services, within the Cabinet for Human Resources, bears the responsibility for developing, maintaining, and administering the policies and procedures; scopes of benefits, and basis for reimbursement for the medical care aspects of the Program. The Department for Medicaid Services makes payments to providers of services within the scope of covered benefits which have been provided to eligible clients.

Determination of the eligibility status of individuals and families for Medicaid benefits is a responsibility of the local Department for Social Insurance Offices which are located in each county of the state,

C. Advisory Council

The Kentucky Medicaid Program is guided in policy-making decisions by the Advisory Council for Medical Assistance. In accordance with the conditions set forth in KRS 205.540, the Council is composed of eighteen (18) members, including the Secretary of the Cabinet for Human Resources, who serves as an ex officio member. The remaining seventeen (17) members are appointed by the Governor to four-year terms. Ten (10) members represent the various professional groups providing services to Program recipients, and are appointed from a list of three (3) nominees submitted by the applicable professional associations. The other seven (7) members are lay citizens.

In accordance with the statutes, the Advisory Council meets at least every three (3) months and as often as deemed necessary to accomplish their objectives.

In addition to the Advisory Council, the statutes make provision for a five or six-member technical advisory committee for certain provider groups and recipients. Membership on the technical advisory committees is decided by the professional organization that the technical advisory committee represents. The technical advisory committee provide for a broad professional representation to the Advisory Council.

All services are reviewed for recipient and provider abuse. Willful abuse by the provider may result in his suspension from Program participation. Abuse by the recipient may result in surveillance of the payable services he receives.

No claims shall be paid for services outside the scope of allowable benefits within, a particular specialty. Likewise, no claim shall be paid for services that require, but do not have, prior authorization by the Medicaid Program.

No claims shall be paid for medically unnecessary items, services, or supplies.

When a recipient makes payment for a covered service, and the payment is accepted by the provider as either partial payment or payment in full for that service, no responsibility for reimbursement shall be attached to the Department and no bill for the same service shall be paid by the Cabinet.

E. Public Law 92-603

Section 1909. (a) Whoever--

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment.

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, of (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or

fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five (5) years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one (1) year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of any offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one (1) year) as it deems appropriate; but the imposition of a limitation, restriction; or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b) (1) Whoever knowingly and willfully solicits or receives any renumeration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in case or in kind---,

F. Kentucky Patient Access and Care System (KenPAC)

KenPAC is a statewide patient care system which, as an adjunct to the Medicaid Program, provides certain categories of medical recipients with a primary physician or family doctor. Only those Medicaid recipients who receive medical assistance under the Aid to Families with Dependent Children (AFDC), or AFDC-related categories are covered by KenPAC. Specifically excluded are: the aged, blind, and disabled categories of recipients; nursing facility (NF), and personal care (PC) residents; mental hospital patients; foster care cases; refugee cases; all spend-down cases; and all Lock-In cases. To aid in distinguishing from regular Medicaid recipients, the KenPAC recipients have a green Medicaid card with the name, address, and telephone number of their primary care provider.

c. Three-year (3) educational program Diploma Graduate with two (2) years of experience in a mental health setting.

d. Two-year (2) educational program Associate Degree in Nursing (ADN) with three (3) years of experience in a mental health setting.

The psychiatric nurse shall plan and supervise nursing services for psychiatric client care, and coordinate and supervise services rendered by nursing personnel with those rendered by other team administration, other departments, and medical staff in formulating policies for psychiatric patient care.

5. Psychiatric Social Worker: The psychiatric social worker shall have an MSW degree from an accredited school of social work. The social worker shall develop complete and accurate case histories, assist patient and family in making mental and emotional adjustment to illness, engage in research and teaching activities, mobilize community resources on behalf of patients, and assist in planning for alternate methods of care.

6. Medical Records Librarian: A medical records librarian, or capable person to perform the duties of a medical records librarian, shall be responsible for ongoing positive controls, for continuity of client care and the client traffic flow; assure that records are maintained, completed and preserved, and that required indexes and registers are maintained and statistical reports prepared; shall be responsible for seeing that information on clients is immediately retrievable, for the establishment of a central records index, and for all elements of service to provide a constant check on continuity of care. In the event that the designated individual is not a qualified medical records librarian, consultation and technical guidance shall be readily available from a person skilled in health record systems.

7. Program Director: The program director shall be a mental health professional who shall be a psychiatrist, psychologist, psychiatric nurse, or qualified social worker. The program **director may also be the executive director.**

D. Additional Staff

Additional staff, as defined in Section IV of this manual, whose services may be reimbursable by Medicaid are:

1. Professional Equivalent: A professional equivalent is defined as an individual who by virtue of a combination of education and experience in the Mental Health field is deemed qualified by the Agency and the Professional Equivalency Review Committee of the Department for Medicaid Services to provide mental health services. The general combination of education and experience-is as follows:

   a. Bachelor's Degree, identical field, 3 years full-time equivalent supervised experience;

   b. Master's degree, identical field, 6 months full-time equivalent supervised experience;

   C. Doctorate degree, identical field.

   Identical fields shall be defined as psychology, sociology, social work and human services as determined by the Professional Equivalency Review Committee. A master's or doctoral degree program that provides a pastoral counseling component may be eligible for consideration.

   The CMHC may recommend an employee for professional equivalency, but final determination of professional equivalency status is determined by Medicaid.

   Please see Appendix IV for the application process for professional equivalency.

2. Mental Health Associate: The mental health associate (MHA) is an individual with a minimum of a bachelor's degree in psychology, sociology, social work, or human services as determined by the Medicaid Program as a mental health field. Only outpatient services provided by the MHA are reimbursable by Medicaid. All outpatient services notes written by the MHA shall be co-signed and there shall be a minimum of a supervisory note once a month. The mental health associate may not provide services to a mentally retarded patient.

3. Certified Psychologist or Psychological Associate: The certified psychologist or psychological associate may be employed by the center to provide covered services under the periodic direct supervision of the licensed psychologist in accordance with KRS 319.

4. Physician: A physician, licensed by the Kentucky Medical Board, may be employed by the Center under the supervision of the psychiatrist to render physical examinations, chemotherapy, emergency and personal care home treatment to clients of the center.

E. Affiliation Agreements

If a center has agreements with other agencies or organizations to provide covered services, these agreements or contracts shall be written and shall include the following:

1. A statement specifying that the resource providing services is in compliance with all existing federal, state, and local laws and regulations governing it.

2. A statement of compliance with the Kentucky Civil Rights Act of 1977, and with the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90, which is as follows:

"No person in the United States shall, on the ground of race, color, national origin, sex, handicap or age be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

3. A statement indicating reasonable assurance that medical services shall be provided by the health resource, when the service is deemed necessary by the clients attending physician.

4. A statement indicating that at the time of transfer, or, in case of emergency, as promptly as possible after the transfer an abstract or copies of pertinent clinical and other information necessary to continue the client's treatment without interruption shall be sent to the facility to which the client transfers. The information shall include the following: current medical, mental status and physical findings; diagnosis; brief summary of the course of treatment followed, pertinent social and psychological information; nursing, medication and dietary information useful in the care of the patient; rehabilitation potential, and pertinent information concerning achievements in rehabilitation.

5. A statement indicating that clients may be transferred from one element of service to another without delay when appropriate for their treatment.

6. A statement indicating that the staff members, treating a client may continue to provide appropriate services during care in other elements of service, when indicated.

   A family physician may continue the medical treatment of the client, if desirable.

7. A statement indicating the basis of reimbursement between the health resource and the center.

8. A statement indicating the conditions by which the agreement may be terminated by either party.

9. Signatures by individuals authorized to execute the agreements on behalf of the resources involved.

10. In addition to the above stated criterion, each agreement with an affiliate shall comply with Section 215, Cost Related to Subcontractors and Affiliate Agreements of the Cabinet for Human Resources Community Mental Health - Mental Retardation Reimbursement Manual.

The provider shall provide to representatives of the Cabinet for Human Resources requested information to substantiate:

1) staff notes detailing service rendered;
2) professional rendering service;
3) type of service rendered and any other requested information necessary to determine on an individual client and service basis whether services are reimbursable by Medicaid.

Failure of the Community Mental Health Center to provide to Cabinet for Human Resources staff requested documentation shall result in denial of payment for those billed services.

G. Application for Participation

A Community Mental Health Center, being in compliance with the standards as outlined in Title II of Public Law 88-164, licensed in accordance with 902 KAR 20:091 and meeting the requirements of Medicaid as set forth in 907 KAR 1:044, may submit an Application for Participation to the Department for Medicaid Services.

The application shall consist of the following:

1. Participation Agreement (MAP-343, Appendix V)
2. Provider Information Sheet, MAP-344 (Appendix VI)

H. Out-of-State Facility

Kentucky Medicaid reimbursement for outpatient psychiatric services provided in an out-of-state facility is limited to the following conditions as specified in Section 1102 of the Social Security Act; Part 431, Paragraph 431.52, (b) Payment for Services:

"A State plan must provide that the State will furnish Medicaid - to 91) a recipient who is a resident of the State while that recipient is in another State, to the same extent that Medicaid is furnished to residents in the State, when

(i) Medical services are needed because of a medical emergency;

(ii) Medical services are needed because the recipient's health would be endangered if he were required to travel to his State of residence;

(iii) The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State; or

(iv) It is general practice for recipients in a particular locality to use medical resources in another State; and

(2) A child for whom the State makes adoption assistance or foster care maintenance payments under Title IV-E of the Act."

The out-of-state facility shall be licensed to provide the community mental health center or outpatient psychiatric services by the state in which it is located, and shall participate as a provider of these services in that state's Title XIX (Medicaid) Program.

An out-of-state facility shall submit a copy of the negotiated participation agreement with their state's Title XIX Program and a copy of that state's Medicaid reimbursement rates for the covered services, in addition to the items listed in paragraph G. Application for Participation, this section.

IV. COVERED SERVICES

Psychiatric services provided by participating mental health centers shall be covered through the Community Mental Health element of the Medicaid Program when provided in accordance with Program policy and guidelines as stated in this section. All covered *services* are listed with applicable procedure codes in Appendix III of this manual.

A. Inpatient Services

Inpatient services provided by a community mental health center shall be designed to provide a therapeutic program for persons requiring full-time care. This shall be utilized only when, and for so long as, no other service of the center is appropriate. The service may be provided in a local general hospital affiliated with the community mental health center, as evidenced by a contract which assures that the appropriate patient services are provided.

1. Initial Inpatient Service

The initial inpatient face-to-face service shall be provided by the center-based psychiatrist before any other inpatient services are payable.

2. Additional Inpatient Services

Following the initial inpatient service, the psychiatrist may determine that the staff psychologist, psychiatric nurse, psychiatric social worker *or* an equivalent professional may provide therapy for the hospitalized recipient. These services shall be reimbursable when provided under the direction of a plan of care approved by the psychiatrist and recorded in the medical record. Documentation of each service provided shall be recorded, signed and available in the client's center-based record.

CMHC clients who are hospitalized for a diagnosis other than a mental illness diagnosis, may continue to receive outpatient services provided as a part of the client's approved plan of treatment. The psychiatrist does not need to see the client prior to the services being provided.

B. Outpatient Services

1. General Information

Outpatient services may be either on-site, which are defined as the CMHC, leased space and donated space, or off-site which includes the client's home, congregate living facility not otherwise reimbursed by Medicaid, school or day care center, senior citizen's center, and Family Resource and Youth Center.

Outpatient services shall be provided on a regularly scheduled basis, with arrangements made for nonscheduled visits during times of increased stress or crisis. The outpatient service shall be the primary point for diagnosis and evaluation of psychiatric problems and the source of referrals to other services and other agencies. All outpatient services shall be provided in accordance with a plan of treatment approved by the center-based psychiatrist.

If outpatient services are provided by a staff member other than the five (5) recognized mental health professionals, the services shall be delivered according to a plan of treatment which has been developed in direct consultation with one (1) of the four (4) principle disciplines and approved and signed by the psychiatrist. Ongoing consultation shall also be maintained with the supervisory staff member throughout the duration of the client's treatment. Staff notes should clearly reflect the input of and supervision by the psychiatrist or supervisory staff member as well as their countersignature.

Outpatient services (with the exception of personal care homes) shall be the only services which may be provided by a staff member other than the five (5) designated mental health professionals (psychiatrist, master social worker, psychologist, psychiatric nurse, and professional equivalent.)

2. Individual Therapy

Individual therapy is defined as a therapeutic intervention provided by a qualified mental health center staff for the purpose of reducing or eliminating the presenting problem of the client. This service may include many different modalities of theory and practice. It shall be provided in a face-to-face, one-on-one encounter between the mental health center staff and the client.

3. Group Therapy

Group therapy shall be therapeutic intervention provided by qualified mental health center staff to a group of persons. A group consists of no more than twelve (12) persons. It is usually for a limited time period (generally 1 to 1 1/2 hours in duration.) In group therapy, clients are involved with one another at a cognitive and emotional level.

Group therapy focuses on the emotional and psychological needs of the clients as evidenced in each client's plan of treatment. Group therapy centers around subjects such as building and maintaining healthy relationships, personal goal setting, and the exercise of personal judgement. The subject of each group should be relative to all clients participating in the group therapy. Group therapy is distinct from therapeutic rehabilitation services which offer group activities in a therapeutic environment that focus on the development and restoration of the skills of daily living.

Group therapy shall not include physical exercise, recreational, educational, or social activities.

4. Family Therapy

Family therapy shall be a therapeutic intervention plan for all members of either the client's immediate household or extended family members who have close assocation with the client. The need for family therapy shall be so stated in the client's plan of treatment. Family therapy services shall be for the benefit of the client and shall be billed under that individual client's MAID number.

5. Collateral Services

Collateral services shall be limited to recipients under the age of twenty-one (21), who are clients of the CMHC.

Definition:

Collateral services are face-to-face encounters with parents, legal representative, school personnel or other persons in a position of custodial control or supervision of the client, for the purpose of providing counseling or consultation on behalf of a client in accordance with an established plan of care.

Persons in a role of supervision may include day care providers, houseparents, camp counselor, patient's physician, or a social worker with case management responsibility who is not employed by the CMHC.

The services shall be provided by qualified mental health center staff, (psychologist, professional equivalent, psychiatric nurse, social worker, mental health associate) and may include consultation, counseling, assessment, family support on behalf of the child with a focus to accomplish the goals outlined in the plans of treatment. The services'may be provided on or off-site. Services delivered to more than one (1) person at the same time shall be billed as if the time were spent with an individual client.

The parent or legal representative in a role of supervision of the child shall give written approval for this service. This written approval shall be kept in the recipient's medical record.

A billable unit of service is the actual time spent face-to-face delivering an actual service. Time spent in traveling to and from an off-site visit shall not be billed.

6. Intensive In-Home Services

Intensive in-home services shall be limited to children, under age twenty-one (21), who are at risk of placement outside the home into a psychiatric hospital or hospital unit, residential treatment facility or foster care. Risk of placement shall also be interpreted to include the child who has been returned to the home from a placement and whose family placement is likely to be unstable if intensive in-home services are not provided.

Intensive in-home services include the provision of therapeutic services, with the goal of preventing out-of-home placement by teaching problem solving skills, behavior strategies, normalization activities, and other treatment modalities as appropriate.

Billable services shall be face-to-face encounters with the child or his family. Generally, intensive in-home services would be expected to be provided for a duration of four (4) to six (6) weeks for an average of three (3) hours per week of face-to-face encounters with the child and family. However, duration and intensity may vary depending on the individual case and may range up to three (3) or even six (6) months, and for more time intensive interventions greater than three (3) hours per week. Family of the child includes those individuals who interact with the child in the household in which the child resides or the family with whom unification is planned.

7. Home Visits

Outpatient services may be provided in the patient's place of residence, as long as the place of residence is other than a facility that is eligible for Medicaid participation. Please note that residence in a public institution may preclude eligibility for Medicaid benefits.

Situations in which home visits may be appropriate would include, but not be limited to the following: (1) as part of a beginning assessment in difficult cases, (2) a family crisis in which immediate intervention is needed, (3) as a means of providing outreach in high risk cases, (4) as a means of providing services to homebound individuals, and (5) as a means of helping the client generalize skills to the home setting.

Examples of situations where home visits may be appropriate "as a means of helping a client generalize skills to the home setting" include:

a. Assisting family members and seriously mentally ill clients to defuse stressful situations which occur in the home by assisting them to practice effective communication techniques in that setting.

b. Coaching a mentally ill client to initiate social interactions with others in the home setting. When this becomes stressful and precipitates withdrawal or "inappropriate acting out," intervening with the client to practice relaxation or tension reduction techniques.

c. Intervening with families where domestic violence is a problem to practice fair arguing techniques or to practice face saving withdrawal from an argument.

d. Coaching family members in carrying out new behaviors aimed at helping a schoolphobic child attend school for several mornings until the family can manage without outside support.

e. Observing family members trying to manage a severely acting out child at a period of the day which is very chaotic for them, (e.g., evening meal time) and intervene in the situation to help them improve their behavior management skills.

f. Helping a parent and child communicate in the environment where problems are most likely to occur.

g. Counseling and supporting persons with severe anxiety who are initially too anxious to learn skills outside their home environment.

a. Emergency Services

The emergency service of a community mental health center shall provide immediate mental health care on a twenty-four (24) hours a day, seven (7) days a week basis. This service may be provided in many methods.

All components of the emergency services shall be coordinated into a unified program, with assurance that patients receiving emergency services can be readily transferred to other services of the center as their needs dictate.

9. Personal Care Home Services (PCH)

The Community Mental Health Center may request vendor payment for covered services to eligible recipients in personal care homes by a psychiatrist, psychologist, psychiatric nurse, master social worker or an equivalent professional, provided the services are in accordance with the plan of treatment approved by the psychiatrist. Staff notes shall be recorded for EACH VISIT to EACH RESIDENT of the personal care home, and shall be by the covered professional rendering the service. Resocialization or remotivation groups shall be covered services if these are mental health services provided under the direction of a plan of treatment, and individual staff notes document the client's psychiatric symptoms, progress and need for continued therapy.

CMHC staff shall also describe the resocialization or remotivation group activities and how these group activities facilitate psychiatric therapy. All mental health services, except individual therapies, that are provided in a personal care home shall be covered as personal care home services.

10. Therapeutic Rehabilitation Services for Adults

A therapeutic rehabilitation program of a community mental health center is a goal oriented service for persons with mental illness which provides a therapeutic program for persons who require less than twenty-four ('24) hours a day care but more than outpatient counseling. Therapeutic rehabilitation shall be an effective intervention, the purpose of which is to assure that a person with a psychiatric disability possesses those physical, emotional, and intellectual skills to live, learn, and work in his own particular environment.

Services shall be designed for the development, acquisition, enhancement, and maintenance of social, personal adjustment, and daily living skills. The focus of all services shall be on helping clients to develop and maintain a healthy self-esteem. Clients shall be encouraged to retain the fullest possible control of their lives, to set their own rehabilitation goals. and to participate fully in decisions affecting their own lives and future:

Medicaid shall make payment for eligible clients in therapeutic rehabilitation programs if specified by a treatment plan approved and signed by the psychiatrist and if the following requirements are met:

a. A psychiatrist shall be present in the therapeutic rehabilitation program on a regularly scheduled basis, at least monthly, and shall assume clinical responsibility for all patients, including the development of the plan of treatment.

b. The program shall have direct supervision by the psychiatrist, psychologist, psychiatric nurse, master degree social worker or a professional equivalent. This professional shall be present in the therapeutic rehabilitation program to provide direct, ongoing supervision and to serve as a source of guidance for other members of the therapeutic team.

11. Therapeutic Rehabilitation Services for Children

Children's therapeutic rehabilitation program shall be a goal oriented program for children under age twenty-one (21) who have a mental health diagnosis (DSM IIIR), and who require more than intermittent outpatient services. The need for this level of intervention shall be identified by the appropriate mental health center staff and shall be indicated in the child's plan of treatment. Therapeutic rehabilitation shall be an effective daily intervention plan to develop, enhance, and maintain social, personal adjustment, and daily living skills, as well as the child's self-esteem. These services supplement clinical services such as individual, group, and family therapy. The focus of all services shall be to assist the child in developing a healthy self-concept and to develop the ability to function in the community.

The program shall have the direct supervision of a psychiatrist, psychologist, psychiatric nurse, master degree social worker or a professional equivalent. This professional shall be present in the therapeutic rehabilitation program to provide direct, ongoing supervision and to serve as a source of guidance for other members of the therapeutic team.

A psychiatrist shall be present in the therapeutic rehabilitation program on a regularly scheduled basis, at least monthly, and shall assume clinical responsibility for all clients, including the development of a plan of treatment. Treatment plans shall be reviewed and updated by staff at least every three (3) months.

A weekly summary note shall be used to document billable services. Staff notes shall be written by the person providing the service and cosigned, when appropriate, by the qualified mental health center staff. The weekly summary note shall reflect the goals and objectives identified in the treatment plan. In addition, it shall include an objective description of the child's attitude, reaction to treatment, progress, behavior, suggested changes in treatment, and other information as deemed relative to the child's case. A description of the activities and how the activities were used to facilitate psychiatric therapy shall also be included.

Educational services and needs shall NOT be covered by Medicaid. However, it is recognized that children participating in a therapeutic rehabilitation program have specific educational needs; therefore, the mental health professional and educational system work in a collaborative effort.

Children's therapeutic rehabilitation services may be provided twelve (12) months a year. Individual, group, and family therapies and collateral services may be provided in addition to the therapeutic rehabilitation services.

12. Evaluations, Examinations, Testing

These services shall be diagnostic in nature. Psychiatric evaluations and testing shall be performed only by the psychiatrist. Psychological examinations and testing shall be performed by either the psychologist or psychiatrist. These tests shall be a prelude to therapy. Professional evaluation of all tests shall be handled as administrative costs.

13. Physical Examinations

Physical examinations of clients of the CMHC shall be provided by either the center-based physician or psychiatrist.

14. Services in a Detoxification Setting

The only services covered in a detoxification setting are psychiatric services provided by the center-based psychiatrist;

15. Chemotherapy Services

The medical evaluation of the effectiveness of psychotropic treatments shall be performed by either the physician or psychiatrist.

C. Limitations

1. Diagnosis Deferred

Treatment in a Community Mental Health Center for clients with the above "diagnosis" shall be covered if the services are provided by any of the five (5) recognized mental health professionals. Recording of the diagnosis in the client's record by the third visit shall be a requisite for Medicaid payment.

2. Speech Disturbance

Medicaid shall reimburse the community mental health center for the services of a psychiatrist or psychologist to a client with the diagnosis-of a Speech Disturbance which is symptomatic of a psychiatric problem. Speech therapy shall be considered outside the scope of Program benefits of the discipline providing speech therapy.

3. Services to Persons with Mental Retardation

When the client's diagnosis is mental retardation, the client shall have an additional psychiatric diagnosis substantiating the need for psychiatric treatment. Diagnoses of developmental disorders, i.e., learning disabilities, shall not be acceptable. Services rendered to persons with mental retardation in need of psychiatric services by a psychiatrist, psychologist, psychiatric nurse, master social worker or a professional equivalent shall be covered by Medicaid when rendered in accordance with the psychiatrist's plan of treatment. The staff note shall document the psychiatric treatment rendered.

4. Group Therapy

Group therapy services shall be limited to groups of twelve (12) or fewer per mental health center staff. Clients shall be limited to a maximum of three (3) hours of group therapy per day.

5. Individual Therapy

Individual therapy services shall be limited to a maximum of three (3) hours per day.

D. Non-Covered Services

The following services shall NOT be payable by the community mental health element of Medicaid.

1. Speech Therapy.

2. Services provided to residents of nursing facilities.

3. Substance abuse services, including institutional or inpatient care services for patients with a diagnosis of substance abuse.

4. Services to the mentally retarded, without documentation of an additional psychiatric diagnosis.

5. Psychiatric or Psychological testing for other agencies such as courts or schools, that does not result in the client receiving psychiatric intervention or therapy.

6. Consultation, Educational services, or Collateral Therapy for Ages 21 and Over

   Consultation or third party contacts shall be outside the scope of covered benefits. Covered services. require direct patient contact except collateral services for children under age twenty-one (21), when a part of the plan of care.

7. Telephone calls or contacts.

8. Travel time.

9. Field trips and other off-site activities.

10. Recreational, social, and physical exercise activity groups.

These limitations and non-covered services shall be monitored by the Department using a combination of system edits during claims processing and of post-payment reviews and audits. Payment for any services provided outside of the scope of covered benefits shall be refunded to the Department for Medicaid Services.

V. REIMBURSEMENT

A. In-State Providers

Financial reimbursement for covered community mental health services provided to eligible Medicaid recipients shall be made directly to licensed participating Community Mental Health Centers on the basis of a prospective cost reimbursement system in accordance with the policies and principles set forth by the Cabinet for Human Resources Community Mental Health- Mental Retardation Reimbursement Manual.

Medicaid reserves the right to question services billed to the Program. The medical review staff are qualified professional people bound by confidentiality when evaluating documents from a client's record; and all information submitted as documentation for services rendered shall be handled in a confidential manner.

Billed services that are not substantiated or confirmed by staff notes, signatures, or other supporting documentation when requested by Program staff shall be denied for payment on a post- payment basis. This also includes services for which staff notes are requested but not provided by a center. If payment for the unsupported services has been made, a refund shall be requested; or the amount owed shall be withheld from a future payment.

B. Out-of-State Providers

Medicaid may make payment to out-of-state providers under circumstances described in Conditions of Participation, who are appropriately licensed, participate with their State's Title XIX Medicaid Program, and have met Medicaid conditions of participation for Community Mental Health Services. The payment rate shall be the lower of 1) submitted charges, 2) the facility's rate as set by the State Medicaid agency, or 3) the upper limit in effect for Kentucky providers.

C. Duplicate or Inappropriate Payments

Any duplicate or inappropriate payment by Medicaid, whether due to erroneous billing or payment system faults, shall be refunded to Medicaid. Refund checks shall be made payable to "Kentucky State Treasurer" and sent immediately to:

EDS
P.O. Box 2009
Frankfort, KY 40602

ATTN: Financial Services

Failure to refund a duplicate or inappropriate payment may be interpreted as fraud or abuse, and prosecuted.

D. Identification of Third Party Resources

Pursuant to KRS 205.662, prior to billing the Kentucky Medicaid Program all participating providers shall submit billings for medical services to a third party when the vendor has prior knowledge that a third party may be liable for payment of the services.

In order to identify those clients who may be covered through a variety of health insurance resources, the provider shall inquire if the client meets any of the following conditions:

-If the client is married or working, inquire about possible health insurance through the client or spouse's employer;

-If the client is a minor, ask about insurance the mother, father, or guardian may carry on the client;

SECTION VI - COMPLETION OF INVOICE FORM

VI. COMPLETION OF INVOICE FORM

A. General Billing Information

The Health Insurance Claim Form (HCFA-1500), (12/90) is used to bill for services provided by a Community Mental Health Center to eligi-. ble Medicaid recipients.

The original of the two part invoice set shall be submitted to EDS. The yellow copy of the invoice shall be retained by the provider as a record of claim submittal,

Invoices shall be mailed to:

E.D.S.
P.O. Box 2018
Frankfort, Kentucky 40602

Claims for covered services to eligible Title XIX recipients shall be received by EDS within twelve (12) months of the date of service.

Claims with a service date more than twelve (12) months old can be considered for processing only with appropriate documentation such as one or more of the following: Remittance Statements which verify timely billing, backdated MAID cards, Social Security documents, correspondence describing extenuating circumstances, action sheets, Return to Provider Letters, Medicare Explanation of Medicare Benefits, etc.

All claims shall be sent to EDS for processing.

B. General Billing Clarification

1. A separate billing form shall be used for each client.

2. A separate line shall be used for each service billed.

3. An individual procedure code shall be payable only one (1) time per date of service. Units will denote the time involved. However, if a person receives more than one different service per date, both may be billed.

4. The center's usual and customary charges shall be entered for all services billed.

5. Units of service shall be entered for each service billed.

6. Units of service shall denote time involved in delivering each procedure. Charges shall be as follows: total of units rendered times usual and customary charge per unit.

7. Therapeutic Rehabilitation is billed by the procedure code of the professional in charge. Do not bill for any additional support staff.

C. Completion of the Health Insurance Claim Form

An example of the Health Insurance Claim Form (HCFA-1500), (12/90) may be found in Appendix XII. Instructions for the proper completion of this form are presented below.

IMPORTANT: The client's Kentucky Medical Assistance Identification Card should be carefully checked to see that the client's name appears on the card and that the card is valid for the period of time in which the services are to be rendered. You shall not be paid -for services rendered to an ineligible person. MAID cards are issued monthly.

SECTION VI - COMPLETION OF INVOICE FORM

BLOCK NO.	ITEM DESCRIPTION
2	Patient's Name Enter the client's last name, first name, middle initial exactly as it appears on the current Medical Assistance Identification (MAID) card.
9A	Insured's Policy or Group Number Enter the client's ten digit Medical Assistance Identification (MAID) number exactly as it appears on the current MAID cards.
10B, C	Accident Check the appropriate block if treatment rendered was necessitated by some form of accident.
11	INSURED'S POLICY GROUP OR FECA NUMBER Complete if the client has any kind of private health insurance that has made a payment, other than Medicare.
11C	INSURANCE PLAN NAME OR PROGRAM NAME Enter the insurance name and program name.
21	Diagnosis Code Enter the appropriate DSM-III R diagnosis code for the diagnosis which the services billed are being rendered as treatment. Enter any additional diagnosis for which services billed on this statement are being rendered as treatment or the condition of the patient that is secondary to the treated diagnosis, e.g., Mental Retardation.
24A	Date of Service Enter the date on which each service was rendered in month, day, year sequence, and numeric format. For example, July 1, 1993 would be entered as 07-01-93.

SECTION VI - COMPLETION OF INVOICE FORM

BLOCK NO.	ITEM DESCRIPTION
24B	Place of Service Enter the appropriate two digit place of service code identifying where the services were performed.
24D	Procedures, Services, or Supplies CPT/HCPCS Enter the five (5) digit procedure code which identifies the service provided. All covered procedures are listed with corresponding procedure code in Appendix III of this manual. MODIFIER Enter the one (1) digit code identifying the type of professional who provided the service. Then enter the employee's identifying number, which may be up to four (4) digits.
24E	Diagnosis Code Indicator Transfer "1", "2", "3", or "4" from field 21 to indicate which diagnosis is being treated. Do not enter the actual diagnosis code in this field.
24F	Procedure Charge Enter your usual and customary charge for the service rendered.
24G	Days or Units Enter the number of units this procedure was provided on this date of service.

SECTION VI - COMPLETION OF INVOICE FORM

BLOCK NO.	ITEM DESCRIPTION
24H	EPSDT Family Plan Enter an "E" if the treatment rendered was a direct result of an Early and Periodic Screening, Diagnosis and Treatment examination. Enter an "F" if the treatment rendered was a direct result of a Family Planning examination.
26	Patient's Account No. Enter the client account number if desired. EDS will key the first seventeen or fewer digits. This number will appear on the Remittance Statement as the invoice number.
28	Total Charge Enter the total of the individual charges listed in column 24F.
29	Amount Paid Enter the amount received by private insurance, DO NOT INCLUDE Medicare. If private insurance made a payment, block 11 and llc shall be completed.
30	Balance Due ENTER THE AMOUNT RECEIVED FROM MEDICARE. If there is no Medicare payment, no entry is required.
31	Signature/Invoice Date The actual signature of the provider (not a facsimile) or the provider's appointed representative is required. Stamped signatures are not acceptable.
33	Provider Number Enter the name and address of the provider submitting the claim. Beside PIN # enter the eight-digit Medicaid provider number.

SECTION VI - COMPLETION OF INVOICE FORM

D. Billing Instructions for Clients with Medicare

If the Title XIX client has applicable coverage under Title XVIII, Medicare, all billings for CMHC services provided by a physician, psychiatrist or psychologist shall be filed with the Medicare fiscal intermediary before Medicaid can be billed.

1. If Medicare has made a payment for services, complete the HCFA-1500 (12/90) in the same manner as a regular billing, entering the amount received from Medicare in Block #30. Attach a copy of the Explanation of Medicare Benefits (EOMB) to the HCFA-1500 (12/90), and mail to EDS.

2. If Medicare does not make a payment, due either to the allowable amount being applied to the recipient's deductible liability, or a Medicare denial, attach a copy of the EOMB or the statement of denial to the HCFA-1500 (12/90) and submit to EDS.

E. Billing instructions for clients with Health Insurance Coverage (Excluding. Medicare)

1. If a third party carrier has made a payment, enter the amount received in Block #29 of the HCFA-1500 (12/90) and attach the Explanation of Benefits to the claim. If payment was denied, attach a copy of the denial to the HCFA-1500 (12/90).

F. Electronic Claims Submission

Providers submitting claims electronically shall have on file a MAP-380 "Provider Agreement Addendum". If using a billing agency, a MAP-246 "Agreement between the Kentucky Medical Assistance Program and the Electronic Medical Billing Agency" shall be on file.

Security information shall also be assigned by EDS to each provider before claims can be submitted electronically.

APPENDIX III

COMMUNITY MENTAL HEALTH PROCEDURE CODES

Abbreviations

PSY - Psychiatrist
PSYCH - Psychologist
PSY N - Psychiatric Nurse
MSW - Master Social Worker
PE - Professional Equivalent
MHA - Mental Health Associate

Code	Type of Professional
1	Psychiatrist
2	Psychologist
4	Psychiatric Nurse
5	Master Social Worker
6	Professional Equivalent
7	M.D.
8	Mental Health Associate

NOTE: In field 24 D of the HCFA (12/90) claim form, you shall enter a five (5) digit procedure code followed by the appropriate one (1) digit code for the type of professional providing the service and then a four (4) digit employee identifying code, which specifically identifies. the employee who provided the service.

Example: X0150 (Procedure Code) 1 (Type of Professional) 0021 (Employee Identifier)

It shall be the provider's responsibility to maintain, on file, the list of employee identifying codes. This list shall be kept updated and available at all times to the Cabinet for Human Resources personnel for reviewing and copying.

APPENDIX III

COMMUNITY MENTAL HEALTH PROCEDURE CODES

PSYCHIATRIST

X0110 Psychiatrist - Inpatient Follow-up
X0111 Psychiatrist - Inpatient Initial
X0120 Psychiatrist - Adult Therapeutic Rehabilitation
X0121 Psychiatrist - Children's Therapeutic Rehabilitation (Limited to Under Age 21)
X0130 Psychiatrist - Personal Care Home
X0140 Psychiatrist - Emergency
X0150 Psychiatrist - Outpatient/Individual Therapy
X0151 Psychiatrist - Outpatient/Group Therapy
X0152 Psychiatrist - Outpatient/Psychiatric Evaluation
X0153 Psychiatrist - Outpatient/Physicial Exam
X0155 Psychiatrist - Outpatient/Detoxification Unit
X0156 Psychiatrist - Outpatient/which includes Chemotherapy
X0157 Psychiatrist - Outpatient/Family Therapy
X0158 Psychiatrist - Outpatient/Collateral Services (Limited to Under Age 21)
X1159 Psychiatrist - Intensive In-Home (Limited to Under Age 21)

M.D. SUPERVISED BY PSYCHIATRIST

X0730 M.D. - Personal Care Home/Physical Examination
X0740 M.D. - Emergency
X0753 M.D. - Outpatient/Physical Exam
X0756 M.D. - Outpatient/with Chemotherapy

APPENDIX III

COMMUNITY MENTAL HEALTH PROCEDURE CODES

ALL OTHER MENTAL HEALTH PROFESSIONALS

x0010 Other Professional - Inpatient Follow-up Visit (Except MHAs)
x0020 Other Professional - Adult's Therapeutic Rehabilitation
x0021 Other Professional - Children's Therapeutic Rehabilitation
x0030 Other Professional - Personal Care Home (Except MHAs)
x0040 Other Professional - Emergency
x0050 Other Professional - Outpatient/Individual Therapy
X005 1 Other Professional - Outpatient/Group Therapy
x0054 Other Professional - Outpatient/Psychological Exam (Psychologist Only)
x0057 Other Professional - Outpatient/Family Therapy
X0058 Other Professional - Outpatient/Collateral Services (Limited to Under Age 21)
X0059 Other Professional - Outpatient/Intensive In-Home (Limited to Under Age 21)
X0060 Other Professional - Home Visits

APPENDIX IV

PROFESSIONAL EQUIVALENT

Medicaid reimbursement can be made for the services provided by individuals determined by the Community Mental Health Center and confirmed by the Department for Medicaid Services to have professional education and experience equivalent to the four principal disciplines.

I. Definition

"Individuals with equivalent professional education" are persons who by virtue of education, professional training and experience in the provision or delivery of direct mental health services of the type reimbursable by Medicaid are shown (to the satisfaction of the Department) to be qualified to provide mental health services.

II. Documentation

A mental health center desiring to secure reimbursement for services provided by an individual with equivalent professional education shall submit the following data to determine whether the individual does have equivalent professional education:

A. The individual's name, address, employer, date of employment, current job title, and a summary of the individual's current duties. The applicant shall be employed by your agency for not less than six months while providing Medicaid covered services.

B. A legible copy of an offical transcript of the individual's undergraduate and graduate education upon which the mental health center is relying to establish that the individual has equivalent professional education. To this should be added information regarding the professional licensure or certification status of the individual;.

C. A letter of recommendation from the applicant's immediate supervisor.

D. A completed CMHC covered services form. See page 4 of this Appendix. Case Management is not a covered service by the CMHC program and therefore that experience shall not be counted towards professional equivalency.

E. Other information which the mental health center wishes the Department for Medicaid Services to consider when making the determination.

PROFESSIONAL EQUIVALENT

F. Clarifying information requested of the mental health center by the Department for Medicaid Services.

III. Criteria

A. The center shall apply the following criteria to the information obtained and determine whether the individual has equivalent professional education. The center may determine that the individual has equivalent professional education only when the following conditions exist with regard to the individual whose qualifications are at issure; the individual has the following degree, and has for the specified period of time demonstrated professional competence in the provision of mental health services in a supervised setting:

1. BA, identical field, 3 years full-time equivalent supervised experience;

2. Master's degree, identical field, 6 months full-time equivalent supervised experience;

3. Doctorate degree, identical field.

An identical field shall be defined as a Bachelor's degree in psychology, sociology, social work, or human services as determined by the Professional Equivalency Review Committee. A master's degree or doctoral degree program that provides a pastoral counseling component may be eligible for consideration.

B. When determining whether "the individual has demonstrated professional competence in the provision of mental health services," the center shall consider such factors as: supervisory job evaluations; amount of job responsibility; disciplinary action taken by the mental health center against the individual; and such other matters as may show that the individual has provided mental health services in a competent and professional manner.

Nothing in these criteria shall be construed to negate the specific provisions and limitations contained in 907 KAR 1:044 or 902 KAR 20:091. For example: the individual of equivalent professional education cannot be reimbursed for non-covered services, or services payable only when performed by a psychiatrist or clinical psychologist.

IV. Application for Professional Equivalency Determination

The center shall submit to the Department for Medicaid Services all information on which the decision regarding equivalency has been made, and is requested to summarize the most essential points considered in determining the equivalency status. The Department for Medicaid Services shall provide to the mental health center a confirmation of the decision as to each individual -for whom the center has requested status as an "individual with equivalent professional education: without undue delay." The Department shall specifiy the beginning date on which the center may begin receiving reimbursement for the individual determined to have equivalent professional education. The beginning date shall be not later than the month of the request for the confirmation of equivalency if the individual met the qualifications in or prior to that month. Change of employment from one community mental health center to another community mental health center does not necessitate that reconfirmation be granted by the Department for Medicaid Services, only that the Department-for Medicaid Services, be provided notification of the change in employment.

If a decision is made that the individual does not have equivalent professional education, the Department shall state clearly its reasons for the decision.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

APPENDIX IV

PROFESSIONAL EQUIVALENT

CMHC COVERED SERVICES

OUTPATIENT SERVICE	PERCENT OF TIME EACH SERVICE	SUPERVISED BY
Therapeutic Rehabilitation		
Individual Therapy		
Group Therapy		
Family Therapy		
Collateral Therapy		
Intensive In-Home Services		
TOTAL		

SIGNATURE AND TITLE OF PERSON REQUESTING PROFESSIONAL EQUIVALENCY

Signature

Title